

FILED JAN 31 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH2978
State File No. 730

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 1 Mo. 34 Ds		c. CITY (If outside corporate limits, write RURAL and give township) Stanton		0470	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hosp.				d. STREET ADDRESS (If rural, give location) Box 298			
3. NAME OF DECEASED (Type or Print) a. (First) ETHEL		b. (Middle) ELIZABETH		c. (Last) SCOTT		4. DATE OF DEATH (Month) (Day) (Year) 1-22-51	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH 11-22-49	
9. AGE (In years last birthday) 1 yr.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Samuel R. Scott		13b. MOTHER'S MAIDEN NAME Betty Boyz		14. NAME OF HUSBAND OR WIFE nil --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME L. Stanton		ADDRESS 500 So. Kingshighway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tracheo-esophageal fistula and stenosis (part op.) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumonia, lobar DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 14 mo. 3 wk. 7562	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from 11-28 , 1950, to 1-22 , 1951, that I last saw the deceased alive on 1-22 , 1951, and that death occurred at 9:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE Wm. G. Kluebers MD				23b. ADDRESS Childrens Hospital		23c. DATE SIGNED 1-23-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 1-23-51		24c. NAME OF CEMETERY OR CREMATORY Arcadia Mem. Park		24d. LOCATION (City, town, or county) (State) Wronton, Missouri	
DATE REC'D BY LOCAL JAN 23 1951		REGISTRAR'S SIGNATURE J. B. Koster		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~me~~ by Me

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed..... Eleonora Remelins

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.